

# **Pre-Admission Screening & Resident Review (PASRR)**

## **Online Screening System Training**

December 2013



*Our Mission:*

Improving health care access  
and outcomes for the people  
we serve while demonstrating sound  
stewardship of financial resources



# What you will learn

- Roles and Responsibilities of Site Administrators
- How to set up your agency's accounts
- How to create a new review step-by-step
- How to enter information for specific types of clients or diagnoses



# Who Needs a PASRR Level I?

- **Any new** admission to a Medicaid Certified Skilled Nursing Facility (SNF), regardless of payer source
- **All respite stays *except*** HCBS Waiver clients requesting a respite stay



# Who's Responsible for Completion?

Per 8.401.184(A):

- **Single Entry Point (SEP)** agencies shall complete Level I's for **known Medicaid** individuals
  - The ULTC 100.2 does NOT need to be submitted to Masspro
- **Hospitals** shall complete Level I's for **non-Medicaid** individuals admitting from the **hospital**
- **Nursing facilities/hospices** shall complete Level I's for **non-Medicaid** individuals admitting from the **community**



# New System

- New PASRR online submission system created
  - Pilot testing of system began November 19, 2013
  - Full roll-out expected January 7, 2014
- Expected benefits
  - Moving from a fax based process to an online system
  - More efficient, less paper, automatic approvals
- Access new online system at [copasrr.com](http://copasrr.com)



# Setting Up Your Accounts

- Each agency is recommended to have **two** Site Administrators
  - At least one site administrator account **must** be established **prior** to registering any standard users
- Each agency can have as many Standard Users as the site administrator deems necessary



# Site Administrator Responsibilities

- Initial sign up of your agency's account
- Assigns and activates users
- Receives email notifications for completed PASRR submission (UPON OUTCOME)
- Able to REVIEW PASRR submissions from main page





# Site Administrator Responsibilities

- Recommended individuals for Site Administrators:
  - Individuals in a supervisory role for PASRR related operations
  - A key PASRR user
  - Administrative-type personnel that will be consistently available and will have a need to track new and completed PASRR submissions through to OUTCOME



# Site Administrator Examples

- **Hospital**

- Case Management Director plus 1 admin or key user staff for all shifts

- **Nursing Home**

- Admission Coordinator plus 1 director / admin to receive all outcomes

- **SEP**

- Supervisory staff plus 1 admin or key staff to track submissions and outcomes

- **CCB**

- Supervisory staff plus 1 admin or other key staff to track submissions and outcomes

- **Hospice**

- Supervisory staff plus 1 admin or key staff to track submissions and outcomes



# Setting Up Your Agency's Administrative and User Accounts



# Site Administrator Registration

Access online system at: [copasrr.com](https://copasrr.com)

## Colorado LTC - PASRR

[Home](#)

[Log In](#)

[User Registration](#)

To **register** for the first time, select **User Registration**

8am - 4pm MT

### Account Login

**Please Enter your Login Credentials**

User Name

Password

Login

[Forgot Password](#)

# Site Administrator Registration

Enter User Information in all required fields

## New User Registration Request

### User Information

NOTE: your account will not be activated until validated and approved by the help desk.

* First Name	Middle Initial	* Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
* Job Title	* Account Type	* † Organization
<input type="text"/>	Site Administrator <input type="button" value="v"/>	<input type="text" value=""/>
* Address 1	Address 2	
<input type="text"/>	<input type="text"/>	
* City	* State	* Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
* Phone Number	Extension	
<input type="text"/>	<input type="text"/>	
* E-Mail Address		
<input type="text"/>		

Account Type:  
**Select**  
Site Administrator



Tip

**Organization not listed?**

Send an email to [coltc@masspro.org](mailto:coltc@masspro.org) to ask to be added

Fields marked with an \* are required.

† If your organization is not listed, please contact the help desk.

# System Registration: Password & Security Questions

8 - 12 characters long  
contains no spaces  
first character must be letter  
contains at least one number  
contains at least one uppercase and one lowercase letter  
contains at least one of the following special characters:  
~ ! @ # \$ % ^ \* +

\* Password

\* Confirm Password

## Security Questions (All Required)

1) In what city or town was your first job?

2) Name of your favorite movie?

3) What was your 10-digit childhood phone number?

4) Name of elementary school last attended?

5) Favorite color?

6) What is your eye color?

- Users must **create a password** following established parameters
- **ALL six** security questions must be answered

Add

# HIPAA Security Requirements

- Form **generated by system** for each Site Administrator
- **Print** form
- **MUST** be signed by official **notary**
- **Fax or email completed forms**  
**Fax: 855-222-3114**  
**Email:**  
[coltc@masspro.org](mailto:coltc@masspro.org)

COLORADO LTC PASRR	
Site Administrator Registration Form	
Mail original, notarized form to: Masspro Inc. Attention: Colorado LTC PASRR 245 Winter Street Waltham, MA 02451	
<i>Form must have original signatures and notary stamp – photocopies or faxes are not accepted</i>	
The following information is required to obtain a Colorado LTC PASRR user account.	
Applicant Name:	nelly, nervous
Job Title:	discharge planner
Organization Name:	.Test Provider A
Address 1:	245 Winter Street
Address 2:	
City, State Zip:	Waltham, MA 02451
Phone Number:	781-419-2785
Fax Number:	855-222-3114
E-Mail Address:	lurban@masspro.org
REGISTRATION NUMBER:	10581
REQUIRED SIGNATURES	
Applicant Signature: _____	Date: _____
On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (print name of notary signer), proved to me through satisfactory evidence of identification, which were _____, be the person whose name is signed on this document in my presence.	
Notary Public (official seal or stamp):	
Notary Signature: _____	

# HIPAA Security Requirements

## Colorado LTC PASRR Site Administrator Registration Form

### Signature of Highest Level Executive

REGISTRATION NUMBER: 10581  
Applicant Name: nelly, nervous  
Organization Name: .Test Provider A

I \_\_\_\_\_ authorize NELLY, NERVOUS to be a Colorado LTC  
(name of highest-level executive)  
Site Administrator for .TEST PROVIDER A.

I understand that the authorized user will be responsible for the following:

- Monitoring Colorado LTC PASRR usage at this organization to ensure security and confidentiality are maintained;
- Serving as a point-of-contact at this organization for information regarding Colorado LTC PASRR transactions.

I understand that, as a security measure, I may be contacted on a future date by the Colorado LTC PASRR Help Desk to verify my position.

\_\_\_\_\_  
Executive (print name)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
E-Mail Address

- Form **generated by system** for each Site Administrator
- **Print** form
- **MUST** be signed by highest level executive for PASRR operations
- **Fax or Email**  
signed copy  
[casey.dills@state.co.us](mailto:casey.dills@state.co.us)  
303-866-2786



# Site Administrator Registration

- Site Administrators (SA) will **fax or email** original registration forms to the State Medicaid Agency
  - Standard Users **do NOT** need to submit forms
  - All users **must** have an accurate email address
- Agency Registration is complete when SA receives an email notification from Masspro
- User Registration is complete when:
  - SA activates each individual user after user self-registers
  - SAs have the option to send email notification to standard users upon activation



# Standard User Registration

## New User Registration Request

### User Information

NOTE: your account will not be activated until validated and approved by your site administrator.

* First Name	Middle Initial	* Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>
* Job Title	* Account Type	* † Organization
<input type="text"/>	Standard User <input type="button" value="v"/>	<input type="button" value="v"/>
* Address 1	Address 2	
<input type="text"/>	<input type="text"/>	
* City	* State	* Zip Code
<input type="text"/>	<input type="button" value="v"/>	<input type="text"/>
* Phone Number	Extension	
<input type="text"/>	<input type="text"/>	
* E-Mail Address	<input type="text"/>	

Account Type:  
**Select**  
Standard User



Tip

**Organization not listed?**

**Site Administrators must be activated**  
Contact your agency's site administrator

Fields marked with an \* are required.

† If your organization is not listed, please contact the help desk.

# System Registration: Password & Security Questions

8 - 12 characters long  
contains no spaces  
first character must be letter  
contains at least one number  
contains at least one uppercase and one lowercase letter  
contains at least one of the following special characters:  
~ ! @ # \$ % ^ \* +

\* Password

\* Confirm Password

## Security Questions (All Required)

1) In what city or town was your first job?

2) Name of your favorite movie?

3) What was your 10-digit childhood phone number?

4) Name of elementary school last attended?

5) Favorite color?

6) What is your eye color?

- Users must **create a password** following established parameters
- **ALL six** security questions must be answered

# Activating or Modifying User Accounts

Site Administrator **must activate each**  
Standard User Account before it can be used

## Colorado LTC - PASRR Administration

### Main Menu

- [User Accounts](#)
- [Colorado LTC – PASRR Home](#)
- [Log Out](#)

**Login as**  
Site Administrator

**Select User Accounts**

## User Accounts

Reg Number: Name: Account  
Status:

[Pending V]

[Filter]

REG NUM	Name	User Name
10719	Flintstone, Wilma	<a href="#">wflintstone@vivage.com</a>
10720	Rubble, Betty	

Click on a **name** to open  
the users account

# Activating or Modifying User Accounts

	Account Status	
Registration Number	10720	
Account Status	<input checked="" type="checkbox"/> Active <input type="checkbox"/> Pending <input type="checkbox"/> Disabled (0 login failures) <input type="checkbox"/> Invalid <input type="checkbox"/> Expired <input type="checkbox"/> Notify User of Status Change <b>Generate Temporary Password</b>	<div>Select <b>Active</b> to activate account</div> <div>Option: Select <b>Notify User of Status Change</b> to send an email to user</div>
Application Privileges	<input checked="" type="checkbox"/> PASRR <input type="checkbox"/> Read-Only <input checked="" type="checkbox"/> Write	
Created	SUSER, 11/20/2013 15	

Account Status:  
**Select**  
Read-Only or Write access

**Activation Complete** - User is ready to enter PASRR

# Entering Client Information into the System



# Homeless Client Scenario

Female Client

Currently homeless

Diagnosed with Bi-Polar disorder

Admitting from community

In the next series of slides, we will show how to create a new review for this client



# Creating a New Review

[Home](#)

[Log Out](#)

[User Registration](#)

[Change Password](#)

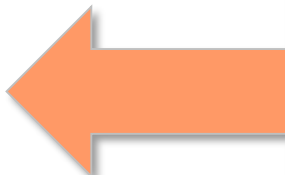
[Change Account Settings](#)

---

## **Review**

[View PASRR Reviews](#)

[Create PASRR Review](#)



Click **Create PASRR Review** to create a new Level 1 review

---

## **CO LTC PASRR DEMO Help Desk**

**Phone:** 855-222-3112

**Fax:** 855-222-3114

**Email:** [coltc@masspro.org](mailto:coltc@masspro.org)

Monday - Friday

8am - 4pm MT



# Creating a New Review

## Pre-Admission and Resident Review (PASRR) Level 1, Version 1.0

### Create Patient Record

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	N	N	N	N

**Enter all Client  
Information**

Fields marked with an  
**asterisk** are required

**PATIENT INFORMATION**

1. Patient

First Name \*

Middle Initial

Last Name \*

Social Security # \*

Date of Birth \*

Gender \*

Race \*

Other Race

Homeless \*

☐ No ☐ Yes

Home Address

City

State

Zip

☐ Home address unknown

Create Review

\* indicates a required field

Click **Create Review** when finished

  
**Tip**

If 'Other' is selected in the Race drop-down menu, a value **must** be entered in the **Other Race** field

# Patient Information Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR	987-66-5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD ☐ MI ☐ MH Meds ☐ Serious SX ☐ Dementia Meds ☐

[Print Review](#)

Client information  
**appears** at top  
of screen

First Name Middle Initial Last Name

BIPOLAR W

Social Security #

987-66-5432

Date of Birth

01/02/1963

Gender

Female

Homeless

☐ No ☒ Yes

Home Address

City

State

☐ Home address unknown

[Verify Completion](#)

[Advance >>](#)

Tabs along right side  
of screen identify  
each section of  
process

**Not all** tabs need to  
be completed for  
every client

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

Click **Advance** to move to the  
next tab **or** choose a tab from  
the menu

# Admission Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	N	N	N	N

[Print Review](#)

**ADMISSION INFORMATION**  
**Element updated.**

Current Location Name	Current Location Contact	Current Location Phone	<input type="checkbox"/> Phone known
MENTAL HEALTH CENT	JOE	303-555-5555	

Current Location Address	Current Location Type	Reason for Hospital Placement
123 W. MAIN AVE.	Other	

Receiving Nursing Facility	Reason for NF Placement	Payment Method
Beta Provider A	Medical	Private Pay

Expedited Admission Categories  
 Not Applicable

Meets all criteria listed below for 30-Day hospital exemption

- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital, and

Specify condition:

- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable.

Physician Name	Phone	Extension	License Number

Verify Completion   Advance > >

**Gray fields** are dependent on information entered elsewhere about the client

## Example:

If you have **not indicated** that a client has been placed in a hospital, the reason for placement field will be gray and information **cannot** be entered

11. Comments

12. Completion

# MR & DD Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-88- 5432	01/02/1983	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	N	N	N	N	<a href="#">Print Review</a>

**SECTION I: MENTAL RETARDATION & DEVELOPMENTAL DISABILITY**

**Element updated.**

Does the individual have a diagnosis of mental retardation or developmental disability (DD)?

☒ No ☐ Yes

Does the individual have any history of mental retardation or developmental disability (DD)?

☒ No ☐ Yes

Is there presenting evidence of a DD prior to age 22 or suspicion of MR condition that occurred prior to age 22?

☒ No ☐ Yes

Has the individual ever received services for MR/DD?

☒ No ☐ Yes

Agency Name:

1. Patient

2. Admission

**3. MR & DD**

4. Mental Health

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion

If you answer **Yes** to any of these questions, enter the **agency name** responsible

# Mental Health Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	N	N	N

Indicator fields change from **red to green** when a diagnosis is indicated

**SECTION II: MENTAL HEALTH DIAGNOSES**

**Element updated.**

Does the individual have any of the following MH diagnoses?

☐ No ☒ Yes

Please check known or suspected MH diagnoses (see instructions)

☐ Anxiety

☒ Bipolar disorder (manic depression)

☐ Depression (mild or situational) GDS Score:

☐ Major depression

☐ Panic disorder

☐ Paranoid disorder

☐ Personality disorder

☐ Psychotic/delusional disorder

☐ Schizoaffective disorder

☐ Schizophrenia

☐ Somatoform

Patient

Admission

3. MR & DD

**4. Mental Health**

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion

# Mental Health Medications Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1983	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	Y	N	N	N	<a href="#">Print Review</a>

### SECTION III: MENTAL HEALTH MEDICATIONS

**Element updated.**

Excluding PRN medication, has the individual been prescribed anti-anxiety or mood-stabilizing medication within the last 12 months?

☐ No ☒ Yes

If yes, was medication used for (check all that apply):

☒ Mental health

☐ Dementia

☐ Other Specify

**List medications used for mental health only**

Medication	Daily Dosage	Diagnosis
No records found.		

[Add Row](#)

[Verify Completion](#) [Advance >](#)

1. Patient

2. Admission

3. MR & DD

4. Mental Health

**5. MH Medications**

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion

**Only if you select Yes, will you be asked to select what the medication is used for**

**Only if you select Mental Health as the reason for the medication, be asked to list information about each medication**

**Click Add Row to enter information about a medication**

# Mental Health Medications Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-88- 5432	01/02/1983	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SY	Dementia Meds
N	Y	N		

**SECTION III: MENTAL HEALTH**  
**Element updated.**  
Excluding PRN medication, anxiety or mood-stabilizer  
☐ No ☒ Yes  
If yes, was medication used for:  
☒ Mental health  
☐ Dementia  
☐ Other Specify   
**List medications used for**  

Medication	Daily Dose
No records found.	

**Row Details**  
Review ID  
100181  
Medication  
  
Daily dosage (mg/day)  
  
Diagnosis

The **Add Row pop-up** box opens

**Enter** in medication name, daily dose and diagnosis

Click **Submit**

# Mental Health Medications Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

**Note:** the MH Meds indicator has changed from **red** to **green**

## SECTION III: MENTAL HEALTH MEDICATIONS

**Element updated.**

Excluding PRN medication, has the individual been prescribed an antipsychotic, antidepressant, anti-anxiety or mood-stabilizer medication within the past 6 months?

☐ No ☒ Yes

If yes, was medication used for (check all that apply):

☒ Mental health

☐ Dementia

☐ Other Specify

List medications used for mental health only

Medication	Daily Dosage	Diagnosis	
DEPAKOTE	1500mg/day	BIPOLAR	Delete

Add Row **Row added.**

Verify Completion Advance >>

1. Patient

2. Admission

3. MR & DD

4. Mental  
Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

Medication populates in list

Click **Add Row** to enter **additional** meds as needed

Click **Advance** when finished



# Symptoms Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1983	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	Y	Y	N	N	<a href="#">Print Review</a>

## SECTION IV: SERIOUS SYMPTOMS

**Element updated.**

Check if any of the following have been present

- ☐ Self-injurious behavior
- ☐ Suicidal talk
- ☐ Suicide attempt or gestures
- ☐ Excessive tearfulness
- ☐ Altercations, evictions, or unstable employment
- ☐ Physical violence
- ☐ Physical threats
- ☐ Hallucinations or delusions
- ☐ Excessive irritability
- ☐ Psychiatric hospitalization
- ☐ Aggressive/belligerent behavior
- ☒ None

Give details for anything checked above: (max 255 characters)

[minimize](#) | [maximize](#)

[Verify Completion](#)

[Advance >>](#)

Select serious symptoms relevant to the client

You will be asked to **enter any details** you have about the symptoms in the text box

Select **None** if there are no symptoms

1. Patient

2. Admission

3. MR & DD

4. Mental  
Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

# Dementia Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	Y	Y	N	N	<a href="#">Print Review</a>

### SECTION V: DEMENTIA

Dementia diagnosis  
☒ No ☐ Yes

If yes, dementia type:  
☐ Alzheimer's  
☐ Other Specify:   
☐ Unknown

The following corroborative testing or other information is available to verify the presence or progression of dementia:

☐ Dementia workup  
☐ Comprehensive Mental Status Exam  
☐ Other Specify:   
☐ None

Individual has been prescribed antidepressant, antipsychotic, anti-anxiety and/or mood-stabilizing medications for dementia or dementia-related diagnoses  
☐ No ☐ Yes

List medications

Medication	Daily Dosage	On Behalf
No records found.		

Verify Completion [Advance >>](#)

Only if you select **Yes**, will you be asked to select further information

Because **this client does not** have Dementia, no further information is required

Click **Advance** when finished

- 1. Patient
- 2. Admission
- 3. MR & DD
- 4. Mental Health
- 5. MH Medications
- 6. Symptoms
- 7. Dementia**
- 8. Legal
- 9. Categorical Determinations
- 10. Alternative Placement
- 11. Comments
- 12. Completion

# Legal Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	Y	Y	N	N	<a href="#">Print Review</a>

## LEGAL INFORMATION

**Element updated.**

Individual has medical proxy

☐ Yes ☒ No ☐ UTD (unable to determine)

Individual has medical durable power of attorney

☐ Yes ☒ No ☐ UTD (unable to determine)

Individual has legal guardian

☐ Yes ☒ No ☐ UTD (unable to determine)

If yes to any of the above:

Primary legal contact name      Primary legal contact phone

[Verify Completion](#)

[Advance > >](#)

Select **Yes, No or UTD** as appropriate on all questions

If you select **Yes to any** of these you will be asked to provide contact information

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion

# Categorical Determinations Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

Select Yes or No on all questions

## CATEGORICAL DETERMINATIONS

### Element updated.

This screen applies to Categorical Determination admissions for individuals with MMI and/or MR/DD only.

A categorical determination is an allowable nursing facility admission for an individual who HAS indicators of MMI and/or MR/DD, without requirement of a fully completed Level II Evaluation prior to admission. For a categorical determination to be considered, the individual must meet the specific criteria outlined below for the type of categorical determination.

#### Meets all criteria below for 60-Day convalescence

☒ No ☐ Yes

- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital, and
- The attending physician has certified prior to NF admission the individual will require less than 60 calendar days of NF services.

#### Meets criteria for terminal illness

☒ No ☐ Yes

I attest that the MD has certified in writing that the patient has 6 months or less to live and that the physician signed certification will be submitted to Masspro via facsimile within 6 business hours of submission of this form

#### Meets criteria for Severity of illness

☒ No ☐ Yes

The individual is ventilator-dependent or comatose unresponsive

Verify Completion

Advance >>

1. Patient

2. Admission

3. MR & DD

4. Mental  
Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

# Alternative Placement Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1983	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

Print

Alternative Placement **must** be considered for every individual **prior to choosing** facility placement as the lowest level of care needed

## ALTERNATIVE TO NURSING FACILITY PLACEMENT (I.E.) ASSISTED ASSISTANCE, HOME HEALTH, HCBS

Alternative placements have been considered for this individual

☐ No ☐ Yes

If no, reason for alternative placements not being considered: (max 255 characters)  
[minimize](#) | [maximize](#)

Seeking an alternative to nursing facility placement is a requirement of Pre-Admission Screening and Resident Review (PASRR)

Verify Completion

Advance > >

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

# Comments Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

Enter any comments you  
feel necessary to aid in  
Masspro's review

## ADDITIONAL COMMENTS

Additional Comments (max 255 characters)

[minimize](#) | [maximize](#)

Client is a homeless female with bipolar, admitting to the facility with medical needs. She has no serious symptoms and is stabilized on Depakote 750mg BID. |

158/255 characters used

Verify Completion

Advance > >

Click **Verify Completion**  
to check for mistakes  
or missing information

- ent
- mission
- 3. MR & DD
- 4. Mental Health
- 5. MH Medications
- 6. Symptoms
- 7. Dementia
- 8. Legal
- 9. Categorical Determinations
- 10. Alternative Placement
- 11. Comments
- 12. Completion

# Completion Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1983	New	N/A	N/A	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	Y	Y	N	N	<a href="#">Print Review</a>

## COMPLETION STATUS VERIFICATION

Review is complete and ready for submission

[Submit for Approval](#)

Click **Submit for Approval** to submit the review to Masspro

Click **OK** in the pop-up box to continue

Message from webpage

Submitting review for final approval will render this form read-only. No further changes will be possible.

Continue?

**OK** Cancel

1. Patient
2. Admission
3. MR & DD
4. Mental Health
5. MH Medications
6. Symptoms
7. Dementia
8. Legal
9. Categorical Determinations
10. Alternative Placement
11. Comments
12. Completion

# Completion Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	New	N/A	N/A	TRUIZ, 11 17:28
MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds			

## Confirm and Authorize



### Review ID

100181

I certify that I am the authorized Colorado LTC - PASRR DEMO account holder identified by the following user name and password and that I have been granted permission to submit the attached data on behalf of my organization.

### User Name

TAMMIEPROV

### Confirm Password

Submit

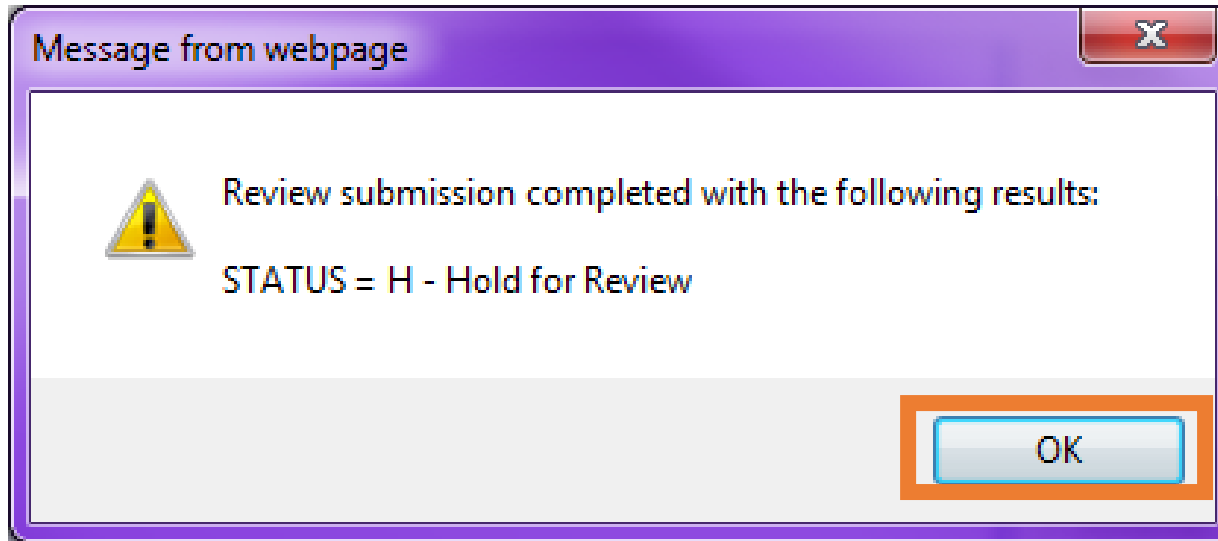
Cancel

Enter your **login password** and  
click **Submit** to  
send the review to Masspro

**Note:** Once submitted, **no changes** can  
be made to the review



# Outcome



After clicking submit, an  
**outcome window** will open

**For this case**, the client requires a  
clinical review to be done by Masspro

**Click OK** to acknowledge

# Outcome

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	Hold	N/A	11/12/13 15:11	TRUIZ, 11/08/13 17:28

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds		
N	Y	Y	N	N	<a href="#">Print Review</a>	<a href="#">Print Outcome</a>

Review is read-only.

**PATIENT INFORMATION**

First Name

Middle Initial

Last Name

BIPOLAR W

HOMELESS

Social Security #

Date of Birth

Gender

Race

Other Race

987-66-5432

01/02/1963

Female

Caucasian

Homeless

☐ No ☒ Yes

Home Address

City

☐ Home address unknown

Advance > >

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Outcome L1

After you have submitted the review, the **screen reverts** to the Patient Tab

All information is **read-only**

Click on the **Outcome L1 Tab**

# Outcome L1 Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	Hold	N/A	11/12/13 15:11	TRUIZ, 11/08/13 17:28

MR or DD   Major MI   MH Meds   Serious SX   Dementia Meds

N   Y   Y   N   N

[Print Review](#)   [Print Outcome](#)

Review is read-only.

**OUTCOME LEVEL 1**  
  
Outcome  
  
  
Outcome Due  
11/13/2013 13:11

Information regarding Masspro's review  
will be available here

Masspro has **six (6) business hours** to  
provide an outcome

The date and time the outcome will  
be available is automatically  
calculated by Masspro

- 1. Patient
- 2. Admission
- 3. MR & DD
- 4. Mental Health
- 5. MH Medications
- 6. Symptoms
- 7. Dementia
- 8. Legal
- 9. Categorical Determinations
- 10. Alternative Placement
- 11. Comments
- 12. Outcome L1

# Printing

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100181	HOMELESS, BIPOLAR W	987-66- 5432	01/02/1963	Hold	N/A	11/12/13 15:11	TRUIZ, 11/08/13 17:28

MR or DD   Major MI   MH Meds   Serious SX   Dementia Meds

N   Y   Y   N   N

[Print Review](#) [Print Outcome](#)

Review is read-only.

## OUTCOME LEVEL 1

Outcome

Outcome Due

11/13/2013 13:11



Tip

At any time, **users**  
**can print** the entire  
review or just the  
outcome

**Do NOT** use the  
browser's print button

Printed outcomes can  
be included in the  
client's file

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Outcome L1

# Viewing PASRR Reviews

[Home](#)

[Log Out](#)

[User Registration](#)

[Change Password](#)

[Change Account Settings](#)

**Review**

[View PASRR Reviews](#)

[Create PASRR Review](#)

**CO LTC PASRR DEMO Help Desk**

**Phone:** 855-222-3112

**Fax:** 855-222-3114

**Email:** [coltc@masspro.org](mailto:coltc@masspro.org)

## Pre-Admission and Resident Review (PASRR) Reviews

Review ID:  Name:  DOB:  SSN:  Status:  Submit Start:  Submit End:

Review ID	Patient	DOB	SSN	Receiving NF	Status	Submitted ▲
100000	HOSPITAL, EXEMPTION	08/14/1972	123-45-6789	.Test Provider C	Approved	11/01/2013
100001	PATTY, PATIENT	05/12/1930	000-12-3456	.Test Provider B	Hold	11/01/2013
100102	DOES, JANE	02/02/1921	785-98-7154	Holly Heights	Approved	11/05/2013
100103	DOESNT, JANE	04/04/1944	789-54-7895	Manorcare Health Servi	Hold	11/05/2013
100104	DOESTOO, JANE	01/06/1924	789-65-4128	Belmont Lodge Health C	Hold	11/06/2013
100121	DOENUT, JANE	04/12/1985	456-87-4598	Palisade Living Center	Approved	11/07/2013
100181	HOMELESS, BIPOLAR W	01/02/1963	987-66-5432	Beta Provider A	Hold	11/12/2013
100122	DOEPPY, JANE	02/18/1945	546-21-9854		New	
100101	DOE, JANE	01/18/1956	147-25-3692	Autumn Heights Health C	New	

Click **View PASRR Reviews** to access previously created PASRR Reviews

A list of all created reviews and their status will appear

Click **on a review** to open it

# Entering a Hospital Exemption



# Hospital Exemption Scenario

Male Client

Currently on Medicare

Diagnosed with mild depression and has medications

Admitting from Hospital

In the next series of slides, we will show the differences in entering a hospital exemption case



# Admission Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD Major MI MH Meds Serious SX Dementia Meds

N N N N N

[Print Review](#)

## ADMISSION INFORMATION

Element updated.

Current Location Name: COMMUNITY HOSPIT  
Current Location Contact: JESSICA  
Current Location Phone: 303-444-4444  
☐ Phone unknown

Current Location Address: COMMUNITY HOSPITA  
Current Location Type: Hospital  
Reason for Hospital Placement: Medical

Receiving Nursing Facility: Beta Provider B  
Reason for NF Placement: Medical  
Payment M: Medicare

### Expedited

#### Admission Categories

30-Day Hospital Exemption

Meets all criteria listed below for 30-day hospital exemption

- Admission to NF directly from hospital after receiving acute m
- Need for NF is required for the condition treated in the hospital

#### Specify condition:

HIP REPLACEMENT

- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable.

Physician Name Phone Extension License Number

DR. SMITH 303-444-4444 8855 DR7531590

[Verify Completion](#) [Advance > >](#)

Select **30-day hospital exemption**

Based on this selection you are prompted to **enter condition and physician information**

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion



# Mental Health Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	N	N	N

The Major MI indicator changes from red to green.

## SECTION II: MENTAL HEALTH DIAGNOSES

Does the individual have any of the following MH diagnoses?

☐ No ☒ Yes

Please check known or suspected MH diagnoses (see instructions)

- ☐ Anxiety
- ☐ Bipolar disorder (manic depression)
- ☒ Depression (mild or situational)
- ☐ Major depression
- ☐ Panic disorder
- ☐ Paranoid disorder
- ☐ Personality disorder
- ☐ Psychotic/delusional disorder
- ☐ Schizoaffective disorder
- ☐ Schizophrenia
- ☐ Somatoform

GDS Score:

GDS Score is required with a Depression diagnosis

Verify Completion

Advance > >

1. Patient
2. Admission
3. MR & DD
4. Mental Health
5. MH Medications
6. Symptoms
7. Dementia
8. Legal
9. Categorical Determinations
10. Alternative Placement
11. Comments
12. Completion

# Mental Health Medications Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	Y	N	N	N	<a href="#">Print Review</a>

### SECTION III: MENTAL HEALTH MEDICATIONS

**Element updated.**

Excluding PRN medication, has the individual been  
anxiety or mood-stabilizer medication within the pa

☐ No ☒ Yes

If yes, was medication used for (check all that appl

☒ Mental health

☐ Dementia

☐ Other Specify

List medications used for mental health only

Medication	Daily Dosage	Diagnosis
No records found.		

1. Patient

2. Admission

3. MR & DD

4. Mental Health

**5. MH Medications**

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion

**Only if you select Yes, will you be asked to select what the medication is used for**

**Only if you select Mental Health as the reason for the medication, be asked to list information about each medication**

**Click Add Row to enter information about a medication**

# Mental Health Medications Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	N	N	N

[Print Review](#)

Row Details

Review ID  
100182

Medication

Daily dosage (mg/day)

Diagnosis

The **Add Row pop-up** box opens

**Enter** in medication name, daily dose and diagnosis

Click **Submit**

Add Row

Row was deleted.

Verify Completion

Advance >>

11. Comments

12. Completion

# Mental Health Medications Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

**Note:** the MH Meds indicator has changed from **red** to **green**

## SECTION III: MENTAL HEALTH MEDICATIONS

**Element updated.**

Excluding PRN medication, has the individual been prescribed an antipsychotic, antidepressant, anti-anxiety or mood-stabilizer medication within the past 6 months?

☐ No ☒ Yes

If yes, was medication used for (check all that apply):

☒ Mental health

☐ Dementia

☐ Other Specify

List medications used for mental health only

Medication	Daily Dosage	Diagnosis	
CYMBALTA	40mg/day	SEASON AFFEC...	Delete

Add Row **Row added.**

Verify Completion Advance >>

1. Patient
2. Admission
3. MR & DD
4. Mental Health
5. MH Medications
6. Symptoms
7. Dementia
8. Legal
9. Categorical Determinations
10. Alternative Placement
11. Comments
12. Completion

Medication populates in list  
Click **Add Row** to enter **additional** meds as needed

Click **Advance** when finished

# Categorical Determinations Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

Select **Yes** or **No** on all questions

This client is estimated to only need a **30-day stay**, not a 60-day stay

## CATEGORICAL DETERMINATIONS

**Element updated.**

This screen applies to Categorical Determination admissions for **only**.

A categorical determination is an allowable nursing facility admission indicators of MMI and/or MR/DD, without requirement of a fully complete admission. For a categorical determination to be considered, the indicators outlined below for the type of categorical determination.

### Meets all criteria below for 60-Day convalescence

☒ No ☐ Yes

- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital, and
- The attending physician has certified prior to NF admission the individual will require less than 60 calendar days of NF services.

### Meets criteria for terminal illness

☒ No ☐ Yes

I attest that the MD has certified in writing that the patient has 6 months or less to live and that the physician signed certification will be submitted to Masspro via facsimile within 6 business hours of submission of this form

### Meets criteria for Severity of illness

☒ No ☐ Yes

The individual is ventilator-dependent or comatose unresponsive

Verify Completion

Advance > >

patient

mission

& DD

ental

h

9. MRI

Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

# Comments Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

Enter **any comments you feel necessary** to aid in Masspro's review

## ADDITIONAL COMMENTS

Element updated.

Additional Comments (max 255 characters)

[minimize](#) | [maximize](#)

Client is a an 82 yr old male with Season Affective Disorder/mild depression taking 20mg Cymbalta BID. Client is discharging from hospital post hip replacement surgery.

170/255 characters used

Verify Completion

Advance > >

Click **Verify Completion** to check for mistakes or missing information

2. Admission

3. MR & DD

4. Mental  
Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

# Completion Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 6543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

[Print Review](#)

**COMPLETION STATUS VERIFICATION**

Review not submitted for final approval.

[Submit for Approval](#)

Click **Submit for Approval** to submit the review to Masspro

Click **OK** in the pop-up box to continue

1. Patient
2. Admission
3. MR & DD
4. Mental Health
5. MH Medications
6. Symptoms
7. Dementia
8. Legal
9. Categorical Determinations
10. Alternative Placement
11. Comments
12. Completion

Message from webpage

Submitting review for final approval will render this form read-only. No further changes will be possible.

Continue?

[OK](#) [Cancel](#)

# Completion Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100182	HOSPITAL, EXEMPTION	998-77- 8543	11/12/1931	New	N/A	N/A	TRUIZ, 11/12/13 16:37

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

[Print Review](#)

### Confirm and Authorize

Review ID  
100182

I certify that I am the authorized Colorado LTC - PASRR DEMO account holder identified by the following user name and password and that I have been granted permission to submit the attached data on behalf of my organization.

User Name  
TAMMIEPROV

Confirm Password  
.....

Enter your **login password** and  
click **Submit** to  
send the review to Masspro

**Note:** Once submitted, *no changes can  
be made to the review*

nt

ession

DD

al

ions

ptoms

entia

l

gical

eterminations

10. Alternative  
Placement

11. Comments

12. Completion



# Entering a Dementia Case with Severe Symptoms



# Dementia Scenario

Male Client

Currently on Medicare

Diagnosed with mild depression and has medications

Admitting from Hospital

In the next series of slides, we will show the differences in entering a dementia case



# Symptoms Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100203	SERIOUS-SYMPTOMS, DEMENTIA	555-55- 5555	05/05/1935	New	N/A	N/A	TRUIZ, 11/19/13 13:59

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
N	N	N	Y	Y	<a href="#">Print Review</a>

## SECTION IV: SERIOUS SYMPTOMS

Check if any of the following have been present in the past 6 months

- ☐ Self-injurious behavior
- ☐ Suicidal talk
- ☐ Suicide attempt or gestures
- ☐ Excessive tearfulness
- ☐ Altercations, evictions, or unstable employment
- ☒ Physical violence
- ☐ Physical threats
- ☐ Hallucinations or delusions
- ☒ Excessive irritability
- ☐ Psychiatric hospitalization
- ☒ Aggressive/belligerent behavior
- ☐ None

Give details for anything checked above: (max 255 characters)

Client becomes easily agitated, angry, and abusive -- often for no apparent reason. has a tendency to curse, hurl insults, and scream. Often refuses treatment.

[minimize](#) | [maximize](#)

160/255 characters used

[Verify Completion](#)

[Advance > >](#)

Client displays **multiple serious symptoms** associated with Alzheimer's

**Additional details** are included in the comment box

1. Patient

2. Admission

3. MR or DD

4. Physical Health

5. Medications

6. Symptoms

7. Dementia

8. Historical

9. Hospitalizations

10. Alternative

11. Placement

12. Comments

13. Completion

# Dementia Tab

MR or DD Major MI MH Meds Serious SX Dementia Meds

N N N Y Y

[Print Review](#)

## SECTION V: DEMENTIA

Dementia diagnosis

☐ No ☒ Yes

If yes, dementia type:

☒ Alzheimer's

☐ Other Specify:

☐ Unknown

The following corroborative testing or other information is progression of dementia

☐ Dementia workup

☒ Comprehensive Mental Status Exam

☐ Other Specify:

☐ None

Individual has been prescribed antidepressant, antipsychotic, anti-anxiety and/or mood-stabilizing medications for dementia or dementia-related diagnoses

☐ No ☒ Yes

List medications

Medication	Daily Dosage	On Beer's List	Exceeds Beer's List	
ARICEPT	23mg/day	No	No	<input type="button" value="Delete"/>
NAMEDA	20mg/day	No	No	<input type="button" value="Delete"/>
QUETIAPINE	175mg/day	Yes	Yes	<input type="button" value="Delete"/>

Row added.

Client has Alzheimer's and is taking a combination of Beer's list and non-Beer's list medications

1. Patient

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Completion

# Outcome L1 Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100203	SERIOUS-SYMPOMS, DEMENTIA	555-55- 5555	05/05/1935	Hold	N/A	11/19/13 15:06	TRUIZ, 11/19/13 13:59

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds		
N	N	N	Y	Y	<a href="#">Print Review</a>	<a href="#">Print Outcome</a>

Review is read-only.

OUTCOME LEVEL 1

Outcome

Outcome Due  
11/20/2013 13:06

Due to this client's serious symptoms and medications, client **requires a Hold** for Masspro clinical review prior to approval

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Outcome L1

# Entering a Hospice Case



# Hospice Scenario

Male Client

Currently on Medicaid

Diagnosed with hallucinations, in end stage of life

Admitting from home

In the next series of slides, we will show the differences in entering a hospice case



# Symptoms Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100221	HOSPICE, ADMIT	888-88-8888	08/08/1958	New	N/A	N/A	TRUIZ, 11/21/13 12:57

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds	
Y	N	N	Y	N	<a href="#">Print Review</a>

## SECTION IV: SERIOUS SYMPTOMS

Check if any of the following have been present in the past 6 months

- ☐ Self-injurious behavior
- ☐ Suicidal talk
- ☐ Suicide attempt or gestures
- ☐ Excessive tearfulness
- ☐ Altercations, evictions, or unstable employment
- ☐ Physical violence
- ☐ Physical threats
- ☒ Hallucinations or delusions
- ☐ Excessive irritability
- ☐ Psychiatric hospitalization
- ☐ Aggressive/belligerent behavior
- ☐ None

Give details for anything checked above: (max 255 characters)

Client is in the end stage of life and suffering from hallucinations

[minimize](#) | [maximize](#)

68/255 characters used

[Verify Completion](#)

[Advance > >](#)

Client displays hallucinations  
as a result of end of life

Additional details are  
included in the **comment box**

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion



# Categorical Determinations Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100221	HOSPICE, ADMIT	888-88-8888	08/08/1958	New	N/A	N/A	TRUIZ, 11/21/13 12:57
MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds			
Y	N	N	Y	N	<a href="#">Print Review</a>		

## CATEGORICAL DETERMINATIONS

This screen applies to Categorical Determination admissions for individuals with MMI and/or MR/DD only.

A categorical determination is an allowable nursing facility admission for an individual who HAS indicators of MMI and/or MR/DD, without requirement of a fully completed Level II Evaluation prior to admission. For a categorical determination to be considered, the individual must meet the specific criteria outlined below for the type of categorical determination.

### Meets all criteria below for 60-Day convalescence

☒ No ☐ Yes

- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital, and
- The attending physician has certified prior to NF admission the individual will require 60 days of NF services.

### Meets criteria for terminal illness

☐ No ☒ Yes

I attest that the MD has certified in writing that the patient has 6 months or less to live. The signed certification will be submitted to Masspro via facsimile within 6 business days of form completion.

### Meets criteria for Severity of illness

☒ No ☐ Yes

The individual is ventilator-dependent or comatose unresponsive

[Verify Completion](#)

[Advance > >](#)

Client meets  
criteria for  
terminal illness

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH  
Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical  
Determinations

10. Alternative  
Placement

11. Comments

12. Completion

# Outcome L1 Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100221	HOSPICE, ADMIT	888-88- 8888	08/08/1958	Approved	COM100165	11/21/13 13:23	TRUIZ, 11/21/13 12:57

MR or DD Major MI MH Meds Serious SX Dementia Meds

Y N N Y N

[Print Review](#) [Print Outcome](#)

Review is read-only.

## OUTCOME LEVEL 1

Outcome

Reason

Approved

[A] Hospice

Auth Number

Approval End Date

COM100165

05/23/2014

Reason Description

Hospice Approval: The NF is responsible for contacting the local OBRA coordinator and/or local CCB, as appropriate, for a status change prior to the approval end date should further NF care be required.

Authorization Date and Time

11/21/2013 13:23

Although this client has a serious symptom, this **client does NOT** require Masspro's clinical review prior to approval

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH Medications

6. Symptoms

7. Dementia

8. Legal

9. Categorical Determinations

10. Alternative Placement

11. Comments

12. Outcome L1

# Entering a PACE Respite Case



# PACE Respite Scenario

Male Client

Currently a PACE client

Diagnosed with anxiety and mild depression

Has one medication

Admitting from home

In the next series of slides, we will show the differences in entering a PACE Respite case



# Admission Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100225	PACE, RESPITE	543-22-0001	02/22/1922	New	N/A	N/A	TRUIZ, 11/26/13 15:56

MR or DD Major MI MH Meds Serious SX Dementia Meds

N	N	N	N	N
---	---	---	---	---

[Print Review](#)

### ADMISSION INFORMATION

**Element updated.**

Current Location Name	Current Location Contact	Current Location Phone
HOME	PACE CAREGIVER	720-444-4444 <input type="checkbox"/> Phone unknown

Current Location Address	Current Location Type	Reason for Hospital Placement
123 STREET A	Home	

Receiving Nursing Facility	Reason for NF Placement	Payment Method	Medicaid Numl
.Test Provider C	Medical	PACE	

**Expedited Admission Categories**

30-Day PACE Respite

**Meets all criteria listed below for 30-Day hospital exemption**

- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital, and

**Specify condition:**

- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable.

Physician Name	Phone	Extension	License Number

- 1. Patient
- 2. Admission
- 3. MR & DD
- 4. Mental Health
- 5. MH

Request for PACE Respite for client

Payment method and Admission Category specify PACE

# Mental Health Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100225	PACE, RESPITE	543-22-0001	02/22/1922	New	N/A	N/A	TRUIZ, 11/26/13 15:56

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	N	N	N

[Print Review](#)

## SECTION II: MENTAL HEALTH DIAGNOSES

**Element updated.**

Does the individual have any of the following MH diagnoses?

☐ No ☒ Yes

Please check known or suspected MH diagnoses (see instructions)

- ☒ Anxiety
- ☐ Bipolar disorder (manic depression)
- ☒ Depression (mild or situational) GDS Score:
- ☐ Major depression
- ☐ Panic disorder
- ☐ Paranoid disorder
- ☐ Personality disorder
- ☐ Psychotic/delusional disorder
- ☐ Schizoaffective disorder
- ☐ Schizophrenia
- ☐ Somatoform

Client has a  
mental health  
diagnosis

1. Patient
2. Admission
3. MR & DD
4. Mental Health
5. MH Medications
6. Symptoms
7. Dementia
8. Legal
9. Categorical Determinations
10. Alternative Placement
11. Comments
12. Completion

# Mental Health Medication Tab

Review ID	Patient Name	SSN	Birthdate	Status	Auth Number	Submitted	Created
100225	PACE, RESPITE	543-22-0001	02/22/1922	New	N/A	N/A	TRUIZ, 11/26/13 15:56

MR or DD	Major MI	MH Meds	Serious SX	Dementia Meds
N	Y	Y	N	N

[Print Review](#)

## SECTION III: MENTAL HEALTH MEDICATIONS

**Element updated.**

Excluding PRN medication, has the individual been prescribed an antipsychotic, antidepressant, anti-anxiety or mood-stabilizer medication within the past 6 months?

☐ No ☒ Yes

If yes, was medication used for (check all that apply):

☒ Mental health

☐ Dementia

☐ Other Specify

List medications used for mental health only

Medication	Daily Dosage	Diagnosis	
XANAX	.75mg/day	ANXIETY	Delete

Client has one  
Mental Health  
medication

[Add Row](#) **Row added.**

[Verify Completion](#) [Advance > >](#)

1. Patient

2. Admission

3. MR & DD

4. Mental Health

5. MH  
Medications

6. Symptoms

7. Dementia

11. Comments

12. Completion

# Outcome L1

Review ID	Patient Name	SSN	Birthdate	Receiving NF
100225	PACE, RESPITE	543-22-0001	02/22/1922	.Test Provider C
Status	Auth Number	Submitted	Created	
Approved	COM100181	11/26/13 16:12	TRUIZ, 11/26/13 15:56	

## OUTCOME LEVEL 1

**Outcome**  
Approved

**Reason**  
30-Day PACE Respite

**Auth Number**  
COM100181

**Approval End Date**  
12/26/2013

**Reason Description**  
30 Day PACE Respite Approval: The NF is responsible for contacting the local OBRA coordinator and/or local CCB, as appropriate, for a status change prior to the approval end date should further NF care be required.

**Authorization Date and Time**  
11/26/2013 16:12



**Tip**

This is the print view  
of the Outcome

**This document is  
what you will include  
in the client's file**

Although client has a  
mental health diagnosis,  
this **client does not require**  
Masspro's clinical review  
prior to approval



# Questions



# Contacts

**Casey Dills O'Donnell**

Title

[casey.dills@state.co.us](mailto:casey.dills@state.co.us)

**Tammie Ruiz**

PASRR Administrator

[tammie.ruiz@state.co.us](mailto:tammie.ruiz@state.co.us)

